NEW YORK STATE | Office of the Medicaid Inspector General

# OMIG AUDIT PROTOCOL – OMH COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAMS (CPEP)

## Revised 06/21/2016

Audit protocols assist the Medicaid provider community in developing programs to evaluate compliance with Medicaid requirements under federal and state statutory and regulatory law. Audit protocols are intended solely as guidance in this effort. This guidance does not constitute rulemaking by the New York State Office of the Medicaid Inspector General (OMIG) and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person. Furthermore, nothing in the audit protocols alters any statutory or regulatory requirement and the absence of any statutory or regulatory requirement from a protocol does not preclude OMIG from enforcing the requirement. In the event of a conflict between statements in the protocols and either statutory or regulatory requirements, the requirements of the statutes and regulations govern.

A Medicaid provider's legal obligations are determined by the applicable federal and state statutory and regulatory law. Audit protocols do not encompass all the current requirements for payment of Medicaid claims for a particular category of service or provider type and, therefore, are not a substitute for a review of the statutory and regulatory law. OMIG cannot provide individual advice or counseling, whether medical, legal, or otherwise. If you are seeking specific advice or counseling, you should contact an attorney, a licensed practitioner or professional, a social services agency representative, or an organization in your local community.

Audit protocols are applied to a specific provider type or category of service in the course of an audit and involve OMIG's application of articulated Medicaid agency policy and the exercise of agency discretion. Audit protocols are used as a guide in the course of an audit to evaluate a provider's compliance with Medicaid requirements and to determine the propriety of Medicaid expended funds. In this effort, OMIG will review and consider any relevant contemporaneous documentation maintained and available in the provider's records to substantiate a claim.

OMIG, consistent with state and federal law, can pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the medical assistance program. Furthermore, audit protocols do not limit or diminish OMIG's authority to recover improperly expended Medicaid funds and OMIG may amend audit protocols as necessary to address identified issues of non-compliance. Additional reasons for amending protocols include, but are not limited to, responding to a hearing decision, litigation decision, or statutory or regulatory change.

# OMIG AUDIT PROTOCOL – OMH COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAMS (CPEP)

## Revised 06/21/2016

| 1. | **Missing Patient Record** |
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| **OMIG Audit Criteria** | If the patient record is not available for review, claims for all dates of service associated with the patient record will be disallowed. |
| **Regulatory References** | 18 NYCRR Section 504.3(a)<br>18 NYCRR Section 540.7(a)(8)<br>14 NYCRR Section 590.12(a) |

| 2. | **No Documentation of Service** |
|---|---|
| **OMIG Audit Criteria** | If the patient medical record or other source information does not document that a service was provided, the claim will be disallowed. |
| **Regulatory References** | 18 NYCRR Section 504.3(a)<br>18 NYCRR Section 540.7(a)(8)<br>14 NYCRR Section 591.4(c) |

| 3. | **Incomplete Brief Emergency Visit** |
|---|---|
| **OMIG Audit Criteria** | Claims for brief emergency visits that are not a face-to-face interaction between a patient and a staff physician will be disallowed. For those persons who are discharged from the comprehensive psychiatric emergency program and who require additional mental health services, the brief emergency visit must include a discharge plan. If documentation of a face-to-face interaction between a patient and a staff physician is missing, the claim for the billed brief emergency visit will be disallowed. |
| **Regulatory References** | 14 NYCRR Section 591.3(a) |

| 4. | **Incomplete Full Emergency Visit** |
|---|---|
| **OMIG Audit Criteria** | Claims for full emergency visits, where documentation of a psychiatric or mental health diagnostic examination, a psychosocial assessment, a medical examination, and a face-to-face interaction between a patient and a psychiatrist is missing, will be disallowed. |
| **Regulatory References** | 14 NYCRR Section 591.3(d) |

| 5. | **Incomplete Crisis Outreach Service** |
|---|---|
| **OMIG Audit Criteria** | Claims for crisis outreach services, where documentation of a clinical assessment and crisis intervention treatment is missing, will be disallowed. |
| **Regulatory References** | 14 NYCRR Section 591.3(b) |

| 6. | **Incomplete Interim Crisis Service** |
|---|---|
| **OMIG Audit Criteria** | Claims for interim crisis services, where documentation of face-to-face contact with a mental health professional for purposes of facilitating a patient's community tenure while waiting for a post-comprehensive psychiatric emergency program visit with a community-based mental health provider is missing, will be disallowed. |
| **Regulatory References** | 14 NYCRR Section 591.3(c)<br>14 NYCRR Section 590.8(d)(2)(ii) and (iii) |

| 7. | **Incomplete Case Record** |
|---|---|
| **OMIG Audit Criteria** | Claims for a full emergency visit, extended observation bed admission, crisis outreach visit or interim crisis service will be disallowed if the case record does not include one or more of the following case record items: diagnosis, assessment of treatment needs, progress notes, or a discharge summary. |
| **Regulatory References** | 14 NYCRR Section 590.12(c),(d), and (e)<br>14 NYCRR Section 591.4(c) |

| 8. | **Brief Emergency Visit Billed as a Full Emergency Visit** |
|---|---|
| **OMIG Audit Criteria** | If a full emergency visit rate is billed when a brief emergency visit is documented, the service will be reduced to a brief emergency visit rate. The difference between the full emergency visit rate and the brief emergency visit rate will be disallowed. |
| **Regulatory References** | 14 NYCRR Section 591.3(a)<br>14 NYCRR Section 591.3(d) |

| 9. | **Brief and Full Emergency Visit Billed for the Same Calendar Day** |
|---|---|
| **OMIG Audit Criteria** | If a brief and full emergency visit are documented and billed for a patient for the same calendar day, only the claim for full emergency visit will be allowed. The claim for the brief emergency visit will be disallowed. |
| **Regulatory References** | 14 NYCRR Section 591.4(d) |

| 10. | **Crisis Outreach and Interim Crisis Service Billed for Same Calendar Day** |
|---|---|
| **OMIG Audit Criteria** | If a crisis outreach service and an interim crisis service are documented and billed for a patient for the same calendar day, only a claim for either one crisis outreach service or one interim crisis service will be allowed. The claim for the other service will be disallowed. |
| **Regulatory References** | 14 NYCRR Section 591.4(e) |

| 11. | **Physician Examination Not Initiated Within Six Hours** |
|---|---|
| **OMIG Audit Criteria** | A patient admitted into the CPEP must be examined by a staff physician within six hours after being received into the emergency room. Although regulations state a patient must be examined within six hours, the claim will be allowed if the patient is examined by a staff physician more than **six** hours *but less than* **nine** hours after being received into the CPEP. Claims for services where the patient is examined by a staff physician more than **nine** hours after being received into the CPEP will be disallowed. |
| **Regulatory References** | 14 NYCRR Section 590.8(b)(1)<br>14 NYCRR Section 591.4(b) |

| 12. | **Medical/Nursing Evaluations Provided Outside the CPEP for a Full Emergency Visit** |
|---|---|
| **OMIG Audit Criteria** | Services provided in a medical/surgical emergency or clinic setting for co-morbid conditions are separately reimbursed. These services shall not substitute, for reimbursement purposes, for medical and nursing evaluations provided in the CPEP. If medical and/or nursing evaluations provided outside the CPEP are utilized by the CPEP, the CPEP is reimbursed for a brief visit only. In these cases, the claim paid the full emergency visit rate amount will be reduced to the brief emergency visit rate amount and the difference disallowed. |
| **Regulatory References** | 14 NYCRR Section 591.4(h) |

| 13. | **Interim Crisis Service Provided in Excess of Five Days from Discharge** |
|---|---|
| **OMIG Audit Criteria** | Claims for interim crisis services performed more than five days after the discharge from the CPEP will be disallowed. |
| **Regulatory References** | 14 NYCRR Section 591.4(f) |

| 14. | **Patient Retained in Emergency Room for More Than 24 Hours** |
|---|---|
| **OMIG Audit Criteria** | Claims for services performed beyond 24 hours in the CPEP will be disallowed unless the patient is admitted to an extended observation bed or a psychiatric inpatient bed. |
| **Regulatory References** | 14 NYCRR Section 590.9(b)(3)<br>14 NYCRR Section 591.4(b) |

| 15. | **Patient Stay in Extended Observation Bed Exceeded 72 Hours** |
|---|---|
| **OMIG Audit Criteria** | Claims for services performed in an extended observation bed in excess of 72 hours from the time the patient was received into the emergency room will be disallowed. |
| **Regulatory References** | 14 NYCRR Section 590.8(b)(2)<br>14 NYCRR Section 591.4(b) |

| 16. | **No Explanation of Benefit (EOB) for Medicare-Covered Service** |
|---|---|
| **OMIG Audit Criteria** | If an EOB for a Medicare-covered service is not provided by an enrolled practitioner, the claim will be disallowed. |
| **Regulatory References** | 18 NYCRR Section 360-7.2<br>18 NYCRR Section 540.6(e)(2)<br>NYS Medicaid Program, Information For All Providers, Policy Guidelines, Versions 2011-1 & 2, Section I |

| 17. | Improper Medicaid Billings for Medicare Crossover Patients |
|---|---|
| **OMIG Audit Criteria** | If a review of Medicare's EOB reveals Medicaid's co-payment is incorrect, the disallowance will be the difference between the Medicaid incorrect co-payment billed and the correct co-payment amount. |
| **Regulatory References** | 18 NYCRR Section 360-7-7(a)<br>18 NYCRR Section 360-7.2<br>18 NYCRR Section 540.6(e)(2)<br>NYS Medicaid Program, Information For All Providers, Policy Guidelines, Versions 2011-1 & 2, Section I |

| 18. | No Explanation of Benefit (EOB) for Third-Party Health Insurance (TPHI)-Covered Service |
|---|---|
| **OMIG Audit Criteria** | If an EOB for a TPHI (commercial carrier)-covered service is not provided, the claim will be disallowed. |
| **Regulatory References** | 18 NYCRR Section 360-7.2<br>18 NYCRR Section 540.6(e)(2)<br>NYS Medicaid Program, Information For All Providers, Policy Guidelines, Versions 2011-1 & 2, Section I |

| 19. | Improper Medicaid Billings for Third-Party Health Insurance (TPHI) Patients |
|---|---|
| **OMIG Audit Criteria** | If a review of the TPHI (commercial carrier) EOB reveals Medicaid's co-payment is incorrect, the disallowance will be the difference between the Medicaid incorrect co-payment billed and the correct co-payment amount. |
| **Regulatory References** | 18 NYCRR Section 360-7.2<br>18 NYCRR Section 540.6(e)(2) |